

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037682

STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar No. 10301

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
26 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR CHRONIC HOSP. INSTITUTION		Length of stay in lb <i>2 days 2039</i>	d. STREET ADDRESS <i>7114 Bancroft</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Christian Clasen</i>		4. DATE OF DEATH Month Day Year <i>10-24-58</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-29-76</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years last birthday) <i>82</i> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. FATHER'S NAME <i>Frederick Clasen</i>		10b. MOTHER'S MAIDEN NAME <i>Marie</i>	11. BIRTHPLACE (City and state or country) <i>Germany</i>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <i>Marie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Records St. Louis Chronic Hospital</i> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Rectum</i>		5800 Arsenal INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		<i>154+</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>20 days</i>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>10-22-58</i> to <i>10-24-58</i> and last saw her alive on <i>10-24-58</i> Death occurred at <i>6:10 a.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED. <i>10/24/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>OCT 27 '58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>City Crematory</i>	23d. LOCATION (City, town, or county) (State) <i>5800 Arsenal St.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Frank O'Donnell 5800 Arsenal St.</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 27 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

NOT EMBALMED

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.